

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010667	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/10/2014
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF SOUTH BEND		STREET ADDRESS, CITY, STATE, ZIP CODE 17441 SR 23 SOUTH BEND, IN 46635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This survey was for the Investigation of Complaint IN00160539.</p> <p>Complaint IN00160539 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: December 10, 2014</p> <p>Facility number: 010667 Provider number: 010667 AIM number: N/A</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: Residential: 41 Total: 41</p> <p>Census payor type: Other: 41 Total: 41</p> <p>Sample: 3</p> <p>Sterling House of South Bend was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00160539.</p> <p>Quality Review 12/12/14 by Lisa McColly</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE